Workforce survey of psychologists in the rehabilitation sector - Victoria

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Introduction

A survey of psychological service provision within Victorian rehabilitation settings was conducted in September 2005. Management representatives (including Senior Psychologists) of thirteen rehabilitation services were contacted by telephone and asked to provide information regarding staffing levels, as well as gaps in service provision. Three of the services provide rehabilitation for specific clinical groups in the community. Eight services were located in the public health sector and attached to acute hospitals, with another two services in the private rehabilitation sector. Each of these hospital-based services had inpatient as well as outpatient programs. Ten programs contacted were in the metropolitan Melbourne area, with an additional three services in regional Victoria.

Managers were asked to identify psychology services most urgently required and to consider the service gaps that have the most impact on the provision of effective rehabilitation services.

Procedure

A simple telephone survey proforma was developed (see Appendix A) and used to guide discussion with the senior psychologists from each participating facility. Some facilities asked for assurances that their particular organisation would not be identifiable in the final report. This assurance was given. Interviews lasted about 20 minutes, although many interviewees spent much additional time talking about contextual organisational issues which impacted on the current employment conditions and role responsibilities of psychologists employed within their particular organisation.

The Survey Proforma

The survey contained questions about the number and qualifications of psychologists employed within the rehabilitation setting, as well as questions about the reporting arrangements for each employed psychologist. In addition there was a question about the services offered and some open-ended questions about the most pressing rehabilitation service needs for particular rehabilitation populations and wider system factors limiting rehabilitation clients’ maximal outcomes. Finally there was a question on psychology-based services most worthy of strengthening within the health system.

Results from survey of psychology staffing establishments

The EFT psychology resource allocation per 10 in-patient beds is provided in Table 1. Presenting the information in this ratio form obscures recognised across-hospital differences in patient complexity and acuity, but has the advantage of enabling comparisons with recommended staffing ratios published by various authorities, including professional associations. The information from the two community-based facilities and the not-for-profit association is not included. Thus Table 1 data relate to the employment of psychologists within the 10 surveyed rehabilitation hospitals or units.
Table 1: Psychology staff-to-patient ratios per 10 patients

<table>
<thead>
<tr>
<th>Rehabilitation Facility</th>
<th>Clinical Psychologist</th>
<th>Neuropsychologist</th>
<th>Other (specialist programs, outpatients, etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>0.30</td>
<td>0.50</td>
<td>3.10 EFT for Outpatients, based on national 1.0 EFT per 20 OP clients</td>
</tr>
<tr>
<td>Hospital B</td>
<td>0.25</td>
<td>0.50</td>
<td>0.20 EFT for Outpatients, estimated 35 of these at any one time</td>
</tr>
<tr>
<td>Hospital C</td>
<td>0.15</td>
<td>0.15</td>
<td>0.15 EFT for Outpatients, estimated 75 of these at any one time</td>
</tr>
<tr>
<td>Hospital D</td>
<td>0.15</td>
<td>0.40</td>
<td>Includes responsibility for OP clients, estimated 35 of these at any one time</td>
</tr>
<tr>
<td>Hospital E</td>
<td>0.15</td>
<td>0.75</td>
<td>Includes responsibility for OP clients, estimated 30 of these at any one time</td>
</tr>
<tr>
<td>Hospital F</td>
<td>0.10</td>
<td>0.50</td>
<td>0.15 EFT for Outpatients, estimated 30 of these at any one time</td>
</tr>
<tr>
<td>Hospital G</td>
<td>0.15</td>
<td>0.05</td>
<td>0.20 EFT for Outpatients, estimated 75 of these at any one time</td>
</tr>
<tr>
<td>Hospital H</td>
<td>0.30</td>
<td>0.40</td>
<td>Includes responsibility for Outpatients</td>
</tr>
<tr>
<td>Hospital I</td>
<td>See Note a</td>
<td>0.20</td>
<td>6.6EFT for all clinical psychology services through-out the hospital system, including Mental Health and Aged Care.</td>
</tr>
<tr>
<td>Hospital J</td>
<td>0.10</td>
<td>0.50</td>
<td>0.5EFT for pain program; 0.4EFT for OP</td>
</tr>
</tbody>
</table>

Note*: No specific allocation of psychologists to rehabilitation beds.

The information in Table 1 indicates that: (a) there is a wide range in current Victorian Psychology establishments; (b) Neuropsychology staffing establishments are generally higher than are clinical psychology staffing establishments (with approximately twice as many neuropsychology, as compared with clinical psychology, positions per 10 in-patient beds). Although it is not apparent from the table, the staffing ratios in the Private Hospitals for both Clinical Psychology and Neuropsychology are higher than the average ratios in the Public Hospital.

Summary of feedback from managers of psychology services in rehabilitation settings

Every psychology service contacted identified need for increased Clinical and Health Psychology resources. Most of rehabilitation programs contacted appeared to be severely limited in their capacity to provide clinical and health psychology services. Managers or Senior Psychologists across services identified the need for an additional one to two EFT of Clinical and Health Psychology staffing.

Managers noted that Clinical and Health Psychologists were unable to provide intensive interventions and longer-term follow-up for people with chronic and complex conditions. One manager noted that because of limitations in staffing levels, only the most complex referrals were referred for clinical psychology input. Several managers noted that less complex referrals are seen by other allied health disciplines such as social work and occupational therapy. One service relies on “training” other allied health disciplines to screen for psychology referrals as a way to ‘triage’ incoming referrals.

One manager summed up the potential pitfalls of this process by noting that "when the client is finally referred to psychology he or she has already been seen by other allied health disciplines -
by the time of referral problems have become entrenched and chronic and are therefore more
difficult to treat."

Over half of the services also identified the need for increased neuropsychology staffing levels,
although the shortage does not appear to be as critical. Neuropsychology managers noted that
they could provide more targeted and comprehensive neuropsychology input with increased
staffing levels.

The issue of limitations placed on the delivery of psychological services was raised by all
psychology managers as an ongoing problem. Many rehabilitation programs were only able to
offer assessment and secondary consultation to their clients. Most services were generally limited
in their capacity to provide intensive psychological interventions, with all services identifying the
need to increase service delivery in the area of direct treatment.

Several managers reported that they were unable to offer group services because of limited
staffing levels. Another manager identified the lack of services for clients requiring longer term and
periodic psychological interventions, such as those with traumatic brain injury, chronic pain, and
post-traumatic stress disorder.

Several managers noted that their staff possessed skills that were underutilised because there was
not the capacity to provide psychological services beyond “the basic essentials”. One manager
noted that psychologists were often relegated to the role of “consultant” when there was so much
more that the profession could offer. The restriction on the work of psychologists in rehabilitation
settings impacts on job satisfaction as psychologists are unable to use the full extent of their skills
and training in the management of their clients.

A significant number of managers described gaps in service provision for clients in community and
home-based rehabilitation programs. The trend in Victoria is for rehabilitation to move into the
community, with a rapid expansion in home-based and outpatient services over the past few years.
All services contacted identified an increased need for clinical and health psychologists and
neuropsychologists to work in outpatient and community settings. One service had recently
undertaken a three-month pilot project, providing neuropsychology services to a “Rehabilitation in
the Home” program. The clinical outcomes obtained from this project were subsequently used to
advocate for increased staffing levels for several home-based rehabilitation teams.

Managers identified the need for increased psychology input to manage specific areas of clinical
practice. These areas include vocational assessment and counselling, working with clients with
post traumatic stress disorder, and managing dual diagnosis clients, such as those with drug and
alcohol along with psychiatric problems. These areas of practice are highly specialized, requiring
the clinician to work across multiple service sectors thereby increasing the complexity of the work
involved. As a consequence of inadequate staffing levels, these clients have limited access to
effective interventions provided by psychologists in rehabilitation settings.

Conclusions
Staffing establishments for psychologists within the surveyed hospitals are uneven and, on
average, below the levels recommended by local authorities such as the Australasian Faculty of
Rehabilitation Medicine (AFRM). This pattern obtains both for Clinical Psychologists and
Neuropsychologists. In terms of the AFRM’s recommended psychology staffing levels, the
surveyed Victorian hospitals are 50% under-resourced in Clinical Psychology and under-resourced
in Neuropsychology by about a third. Most heavily under-resourced are the Public Hospitals rather
than the Private Hospitals.

In terms of the impact of these staffing inadequacies, the situation is even more pressing than it
appears from a comparison of survey results with recommended ratios. As patients are discharged
from hospitals “sicker but quicker”, the importance of hospital-led early intervention initiatives
(particularly in terms of patient health-related knowledge, attitudes and skills) increases. Psychologists are key players in the delivery of such services. Inadequate levels of psychology staffing can be predicted to lead to increased re-admissions for preventable complications.

**Recommendation**
That the Working Group, having reviewed the survey report and incorporated any agreed changes, forward the report to key Society managers and decision-making groups for their further action.